July 7, 1997

Mr. L.E. Hall
[ ]
Lockheed Martin Hanford Company, S7-85
P.O. Box 1500
Richland, WA 99352

Subject: Noncompliance Numbers NTS-RL--PHMC-TANKFARM-1997-0001
NTS-RL--PHMC-TANKFARM-1997-0002
NTS-RL--PHMC-TANKFARM-1997-0003

Dear Mr. Hall:

This letter refers to the Department of Energy's (DOE) investigation of potential violations of the Quality Assurance Rule (QA Rule) nuclear safety requirements identified in the subject reports. On April 27 and 28, 1997, the Office of Enforcement and Investigation personnel met with you and members of your staff. Our purpose was to understand the circumstances leading to the subject noncompliances and your progress in carrying out corrective actions. We are including our Investigation Summary Report with this letter.

The three events involved, as outlined in the enclosed investigation summary report, are (1) on September 17, 1996, Tank Farm personnel attempted to add treated water to [a tank]. The Person-in-Charge failed to follow procedural requirements that caused a 97-gallon spill of clean water inside a radiological containment tent; (2) during October 1996 an Engineering Change Notice (ECN) was initiated by an Lockheed Martin Handford Company (LMHC) employee to obtain heat trace components for a flammable gas monitoring system of a waste tank. The engineer responsible for the ECN release stamp falsified the design verification documentation in the package in order to expedite the purchase request for these components; and (3) on January 17, 1997, LMHC personnel were transferring [radioactive] waste between two tanks [at the] Tank Farm. A leak detector alarm was received while the waste transfer was in process; by design, an automatic shutdown of the transfer pump should have occurred but did not. Because operational procedures were not followed, the transfer process continued for four more hours before shift personnel identified that the transfer pump was still operating.

DOE’s investigation concluded that violations of QA Rule, 830.120 C(2)(i), Work Processes Requirements have likely occurred. A common work control deficiency, failure to follow procedures and administrative work controls, was identified as a causal

factor in all three of these events. Although no adverse consequence resulted from these events, and LMHC did not consider the event involving the unplanned and uncontrolled transfer of waste to have major significance, DOE has concluded when considered collectively, these events represent a broader management concern with respect to the general adequacy of work controls at this nuclear facility. In short, they raise concerns about the potential for adverse consequences at the facility.

When evaluating these issues, DOE considered your brief tenure as the operating contractor for the Tank Farm facility when these events occurred, and the fact that this problem was also known to exist within the prior contractors work control system that you inherited. We have also reviewed your actions and commitments to resolve this problem, including corrective actions for each event. Your action to retrain the work force at the Tank Farm to ensure they understand both the importance and expectation that they follow established work controls, or stop work if those controls do not allow work to be accomplished safely, is appropriate in correcting this problem. In addition, DOE-RL noted the following actions as having a positive effect in beginning to change the culture at the Tank Farms: (1) increased visibility and participation of your management both in the field and with facility operations; and (2) your aggressive role in understanding the root causes and applying lessons learned.

Considering these factors, the Office of Enforcement and Investigation, in coordination with DOE-RL and the program office, has elected to use the discretionary authority provided for in Appendix A to 10 CFR 820 to not pursue potential enforcement actions in these cases. The final decision whether to refrain from taking an enforcement action is contingent upon the adequacy of implementation of the corrective actions. A member of my staff will coordinate with the DOE-RL Price-Anderson Coordinator the review of the effectiveness of your corrective actions as reflected in the events contained in the NTS reports.

If you would like to discuss this matter further, please contact Mr. Dick Trevillian of my staff at (301) 903-3074.

Sincerely,

R. Keith Christopher
Director
Office of Enforcement and Investigation

Enclosure:
Investigation Summary Report